

BDDS Provider Meeting

May 8, 2015

The below topics were discussed in workgroup sessions during the May 8, 2015 DDRS Provider Meeting. The workgroups were convened to discuss various BDDS program areas where service changes are being considered. The discussions focused on ways to enhance service delivery options for individuals and their families, and/or identified changes needed to address new HCBS rules.

HCBS Settings Rule

Question:

Do we have the ability to meet the expectations of CMS under the new rule? -If not, where are the barriers?

Feedback:

Barriers:

- What staff/families are able to provide
- Families' expectations
- How we utilize staff; need for invest in Direct Support Professionals
- Individual choice vs. systemic change
- Consumers cannot explore options
- Consumers are not given time to have experiences/informed choices

Abilities:

- Strong provider network
- Strong advocacy involvement
- Providers have experience adapting to change
- Strong partnerships
- Support from leadership/state gov't
- Would like consistency in DDRS leadership

- How will expenses incurred due to the new rule be paid for-who will pay for it?
- More interpretive guidelines are needed
- Improve explanation of choices "upfront"
- Need to focus on person centered planning
- Educate employers in the community on hiring people with disabilities
- Outreach to gain community trust

Question:

How might service delivery look different under the new HCBS rule? What might some notable differences be for families and participants? What are some notable business changes for Providers that might need to occur based upon these changes?

Feedback:

- Actively engage Direct Support Staff
- Partner with education better -- develop a better understanding of what parents have been told to expect, and develop an understanding of the level and types of supports provided through education system
- How will it be funded?
- Concerns that some won't have natural supports

- Embrace technology for care
- Allow providers to have “acceptable risk”
- Shared responsibility between a group of providers/state when determining culpability after incidents
- Change mindset on/adapt to Adult Family Care model
- More effort on employment-less referring away
- Implement a single service definition
- Increased development of and reliance on natural supports
- More flexibility in scheduling types of daily activities – move away from “It’s Thursday, so we go to McDonald’s” to a more fluid/flexible schedule based on the individual’s daily choices
- Be creative in creating staffing patterns
- Independence building through risk assessment
- Diversity of employment options
- Training prior to and continuing during community employment opportunities
- Creative funding in employment options
- Utilization of enclaves as a stepping stone to competitive employment

Question:

What are some important things to consider when writing a new service definition and setting new expectation for service delivery under the new HCBS settings rule? What language should or should not be used? What communication strategies should be utilized to explain the changes to families and participants? What qualities should be highlighted?

Feedback:

- Flexibility, fluidity
- Communication - Do not rely solely on internet announcements
- Use “peer support”/representatives to help new families
- Have consistency in message (regardless of who’s delivering it – State staff, providers, advocacy groups)
- Deliver message using a variety of methods, taking into account: 1) new/more recent consumers as well as more long-term consumers, and 2) some families/individuals rely heavily on technology to receive information and others prefer more “traditional” forms of communication (e.g. town hall meetings, flyers, etc.)
- Set clear and understandable guidelines – ensure everyone who may read them understands what they mean (State staff, providers, and families/individuals)
- Build on trust
- Avoid jargon/acronyms
- Have a “familiar face” deliver messaging
- Validate fears of consumers/families - address them directly
- Clarification on responsible use of resources for all partners
- Realistic, clear language regarding family requests (e.g. timeframes; roommates, etc)
- Strong team communication
- When writing new definitions be mindful of resources

Question:

How would these systems changes impact the role of case management?

Feedback:

- Roles need to be clearly defined and all parties involved need to have a shared understanding of what those roles are

- It needs to be about what the individual/their team wants
- Currently, case managers are too busy with quality assurance; they need to be a facilitator
- Need to be able to facilitate person centered plan
- There should be “specialists” to handle certain issues (i.e. budget, health, etc.) to free up case manager
- Clarify/transparency throughout BDDS local offices
- Allow flexibility/fluidity amongst services but have consistency through data monitoring (one database funneling info to State)
- Ability to form deeper more meaningful relationships with consumers
- Educate case managers; look at immediate needs
- Speak with person and families/build on their interests
- Clarity of role at every level of provision
- Shift from compliance to person centered outcomes
- Need better knowledge of local resources-create database
- Establish relationships with all involved and remain focused on person being served
- Need team building with case manager-not over using technology/email communication

Person Centered Planning

Question:

Are the current system barriers that exist to do more valuable person centered planning?

Feedback:

- Resource (buckets of allocations)
- Documentation – force to focus on services, age, PCP (e.g. MAPs – future lifelong tool) Advocare tool ISP yearly focus
- CCB working backwards/ focus on \$
- MAPs vs PCP/ night and day comparison
- There is not a good theory of practice/ follow through after training
- How to operationalize/ support providers technically
- Philosophy application
- Intent of meeting- loss of focus/ looking at ratios and documentation/ service driven
- Meeting to “check the boxes” / fear of missing something/ signing documents for individuals
- The individual’s voice is not always heard
- 90 day checklist
- Buckets – “triangularization of person “– adds to behaviors, 3 person settings- lengthy process to change money allocation
- “Prebucket” – do not believe cost would increase in a one bucket system
- True case management
- Unrealistic documentation requirements
- Provider portal- access to PCP/ needs improvements
- Other states pay more for case management- can hire a different level of professional
- Caseloads size makes it hard to get to know person/advocate /higher caseloads than other states
- Hiring a challenge with all staff with rate of pay
- Other states do track time spent with individual- case manager/ quality indicator-length of years
- Rural settings struggle- one day program /across counties transportation issues/lack of providers / wheelchair accessible transportation
- Providers can’t ask State to pay for everything

Question:

What types of training and support is needed to enhance the person centered planning process?

Feedback:

- Facilitator certification program / serve as a resource
- Have staff participate in PCP so increases awareness
- Creative ways to implement the follow-up to assure implementation
- Start meeting with Vision for the Future- goals for next year
- Living document – retrain the brain/ focus
- Distribute the document /access issues in Advocare noted-provider portal
- What is the Good Life and how to move towards it?

Question:

Who would the target audience be for the training?

Feedback:

- Educate individual / how to voice their opinion
- Broaden vision/ don't know what you don't know
- POM – pre-meeting with individuals
- Other States are mandated PCP to assure compliance
- General measures of well-being/ preferences/ choices
- Resource -Michael Small- last here in Indiana 2006
- Self advocates utilized for peer training
- Case managers- “documentation custodians” / have lost the “teeth” advocacy
- Other states pay more for case management- can hire a different level of professional
- Caseloads size makes it hard to get to know person/advocate /higher caseloads than other states

Question:

In what ways should that training be developed?

Feedback:

- CQL or Michael Small
- Skills and values of a facilitator are critical
- Resource tool box – one size doesn't fit all/ understand the benefits of each
- Specific tool for individuals who are nonverbal
- True wrap around – all access to information and input
- Some states do “broker” with PCP facilitator
- Case management – neutral / facilitation vs negotiation- different skill sets
- Case managers are advocates
- Privatization- mediation skills/ PCP facilitator
- Two day training KI Thought Bridge – from Indiana League of the Blind- functional resource

Question:

How would these system changes impact the role of the case management?

Feedback:

- Typical meeting – 30-40 minutes to organize and contact members of team changed/ coordinate time & place/ 8 forms that are prepped for meeting; PCP
- BQIS- corrective actions multiple lines must be added to the annual
- Post Steve Cook and prior to Nicole Norvell's tenure- the focus became “auditing” and resource allocation
- RMT- “Day of Armageddon” painful experience/ what possibly could go wrong
- Oversight should be different- different based on where you live(FSW, 3 person home, family home...)
- Meetings are cancelled due to “shame” of their environment- intrusion –check food supply, etc...; awareness of different ways to live
- If you ask for something three times without receiving it- report to BQIS- current protocol
- A good person centered planning meeting- where are you today, what do you want to learn today, your vision/ future for your life then we figure out how to get you there – what services help teach you that
- Parents and paid service workers may have their own agenda. Need to help individual find their “voice”.

- Case manager helping family members view their adult child and broaden an individual's view/vision.
 - Bucket system hinders quality of life; need to foster natural systems/supports.
 - Priority should be quality of life indicators with resource allocation last.
 - Provider's responsibility also not just case management to person centered planning.
 - Need structure/oversight
 - IT –assistive technology / utilizing technology more to assist in shared resources/ pictures
 - Documents are done- utilization (e.g. Group homes, individuals coming out of institutions) - where are they –in a binder?
 - Future Goals- Changes are coming. Service delivery is not sustainable for decades. The intent is building a sustainable model. Case management is critical. Natural supports and building relationships are critical.
- Need to support individual and family to be supported lifelong – changes will need to occur with thoughtful planning and intentionality to walk with the person throughout their life bridging supports/agencies in the State.

Family Supports

Question:

What feedback have you heard from families about supports that are not currently available that are needed?

Feedback:

- It continues to be difficult to hire qualified staff.
- One provider stated that they are at capacity due to staffing shortages. Others concurred.
- Scheduling of staff is a challenge. Many schedules that need to be filled are short hour and mid-day.
- Parents are looking for assistance in moving their adult child out of their home into a different living arrangement. Some parents are planning years ahead and other needs solutions soon.
- Conversation on how to best keep adult children in the home.

What are the barriers?

Physical limitations.

Need to have a different funding model. For example: vehicle modifications are allowed once in a lifetime. That is not reasonable.

Rural areas are a challenge specifically in the areas of transportation, job development and lack of community support.

Question:

What types of controls could or should be given to participants who choose a relationship based model of care?

Feedback:

- Self Directed Care?
- Case Management able to authorize services up to a certain allocation limit?
- A great amount of time is spent building the relationship – 6 months.
- Training requirements include “what is needed for a healthy family”. Life skills, how to, etc.
- Monitoring will be very different – discussed topics included environmental, health & safety.
- Training needed for care giver stress management.
- Training must be flexible and able to fit a variety of learning styles and needs.
- Specific to self-directed care: when trying to move individuals toward independence the family members are not always the best ones to make decisions. Parents may hold back success and the shift from family to caregiver can be difficult.
- Families will need to embrace suggested changes and these ideas will need to be “sold”.
- It’s important to “pre-address” the issues that will come up.
- How will the public feel about us paying for family to care for family? Prepare to address this.
- Some providers will be un-happy with this change. This type of change occurred 10 years ago in mental health and providers were unhappy.

-Question posed: What about Case Managers authorizing services?

Noted that many nodded an affirmative

Need better training for Case Managers on Family Support.

How would it affect the provider?

We needed a higher level of flexibility on how money is spent – (group was vocal on this subject).

What is the budget? Local decision on how it is paid.

Will need better checks and balances if local decision is expanded.

- Discussed how other States manage the money. For example, allow spending to a specific level and over that amount, approval is required. Ideas such as not penalizing a family for spending less than the allotted amount should be explored.

- FSSA needs to improve the authorization for payment process.

Question:

From the perspective of the Provider, what systems would have to change to make a relationship based model of care more desirable?

Feedback:

- [Repeat of training comments noted under questions 1 and 2.]

- We need to change and the change would be good.

- Some providers are looking for solutions to the current process.

Question:

How would these systems changes impact the role of case management?

Feedback:

-(Case Management points were made throughout Questions 1 and 2. The majority of the comments were related to the need for a higher level of training)

Crisis Supports

Question:

From the perspective of the Provider, what types of crisis supports are needed in order to assist dually diagnosed participants? -On call personnel? -Certain accredited providers with expertise? -Community partners with specific training?

Feedback:

- On call on phone is less effective than onsite response
- People not close enough to quickly get on site-perhaps add satellites
- Partnerships-statewide facilitators could match appropriate crisis providers
- Psychiatrists need to be available for follow along
- Clearly defined criteria of what constitutes "crisis"
- Staff and community partners need training-Police need crisis intervention training
- Provide a resource to community partners
- Alter staffing rates for those qualified and equipped to handle mental health crisis; look into national accreditation for DSP's working with consumers with a dual diagnosis
- Centers specifically used for crisis only-similar to respite
- What local resources are available to offer trainings?

Question:

If training were to be provided to better serve the dually diagnosed population, what would you want that training to look like? -Who is the target audience? -What is the division of responsibilities between the State and Provider for training and retraining? -What role does the family play in training?

Feedback:

- Need to look beyond FSSA and providers for resources-bring in medical community
- Mental Health providers do not have a vehicle similar to I/DD providers
- Need a better system of placement when crisis continues to escalate-reevaluate level of care
- Educate families' when/how to document a crisis/incident-should be an ongoing discussion
- Educate schools; create ongoing discussion
- Train on quality of reports as well as their importance
- What training currently exists?
- Train providers on education and resources for families not yet receiving services
- Offer retreats for families/care givers to meet others in similar situations-create natural supports
- Have support groups/trainings
- Promote NAMI and CHADD as valuable resources

Question:

How would these systems changes impact the role of case management?

Feedback:

- Families moving from CIHW-FSW will need funding/support for crises training
- Offer short-term intensive intervention funding/services
- 8:1 ratio for case management
- Provide more for case manager to work on creating partnerships and supports for families
- During crisis support-case manager could better connect to appropriate resources
- Continuous networking of resources in community

- SPOE needed in crisis management
- 24/7 behaviorist availability